Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS359AGC	A. BUILDING _____ B. WING _____	12/04/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
M S J HOME CARE	**4370 ADELPHI AVENUE LAS VEGAS, NV 89120**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments Surveyor: 28380 The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted in your facility on 12/4/09. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for six Residential Facility for Group beds for elderly and disabled person and/or persons with mental illness. The facility received a grade of A. The following deficiencies were identified:	Y 000		
Y 020	449.190(1)(a)-(e) Contents of License-Administrator's Name NAC 449.190 1. A license to operate a residential facility must include: (a) The name of the administrator of the facility. (b) The name and address of the facility; (c) The type of facility; (d) The maximum number of residents authorized to reside at the facility; and (e) The category of residents who may reside at the facility.	Y 020		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Y 020	Continued From page 1 This Regulation is not met as evidenced by: Surveyor: 28380 Based on observation, record review and interview on 12/4/09, the facility failed to be overseen by a qualified administrator (currently no Administrator of record). Severity: 2 Scope: 3	Y 020		